BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petitiotn for Reinstatement Against:	)	
	)	File No. 10-92-16904
JOSEPH DURANTE, M.D. 72205 Painters Path Palm Desert, CA 92260	)	OAH No. L-9506134
Physician's and Surgeon's Certificate # G-3711	)	

ORDER GRANTING STAY

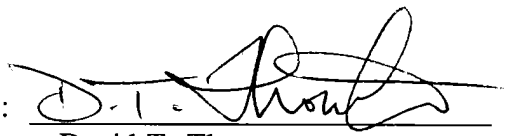
Joseph Durante, M.D. has filed a request for a stay of execution of the Decision with an effective date of August 24, 1996.

Execution is stayed until September 3, 1996.

This Stay is granted solely for the purpose to allow time for the Agency to review and act on the Petition For Reconsideration.

Dated: August 23, 1996

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

By: 

David T. Thornton
Supervising Investigator II

MEDICAL BOARD OF CALIFORNIA
State of California

In the Matter of the Accusation Against: JOSEPH DURANTE, M.D. 72205 Painters Path Palm Desert, California 92260 Physician and Surgeon's Certificate Number G3711, Respondent.	)	OAH No. L-9506134 Case No. 10-92-16904 DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the **Medical Board of California** as its Decision in the above-entitled matter.

This Decision shall become effective on August 24, , 1996.

IT IS SO ORDERED this 25 day of July , 1996.

MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____

Ira Lubell, M.D.
Chair, Panel A
Division of Medical Quality

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	Case No. 10-92-16904
JOSEPH DURANTE, M.D. 72205 Painters Path Palm Desert, CA 92260	)	OAH No. L-9506134
Physician and Surgeon's Certificate number G3711	)	
Respondent.	)	

PROPOSED DECISION

This matter was heard by Samuel D. Reyes, Administrative Law Judge, Office of Administrative Hearings, in San Diego, California, on May 9, 10, 13, 14, 15, and 16, 1996, and in Los Angeles, California, on June 6, 1996.

Sanford Feldman, Deputy Attorney General, represented Dixon Arnett ("complainant"). Jay N. Hartz, Attorney at Law, represented respondent.

Oral and documentary evidence, and evidence by oral stipulation on the record, was received at the hearing. The record was left open for the parties to submit briefs regarding the issue of costs. Complainant's brief, marked for identification as Exhibit 19, was received on June 10, 1996. Respondent's reply brief, marked for identification as Exhibit M, was received on June 14, 1996. The matter was submitted for decision on June 14, 1996. The Administrative Law Judge makes the following findings of fact.

Findings of Fact

1. Complainant filed the Accusation solely in his official capacity as Executive Director, Medical Board of California ("Board").

2. Respondent received his Medical Degree in 1955 from the New York State College of Medicine, Brooklyn, New York. One year later he completed a rotating internship at the Long Beach Veterans Hospital, Long Beach, California. After a one-year general practice residency at the Kaiser Foundation Hospital in Oakland, California, respondent entered a three-year OB/GYN residency at the Kaiser Foundation Hospital on Sunset Boulevard in Los Angeles, California. In 1960, after completing his residency, respondent moved to the Palm Desert, California, area where he has remained in the private practice of medicine.

3. On September 6, 1956, the Board issued Physician and Surgeon's certificate number G 3711 to respondent, which certificate expires January 31, 1997. The certificate has not been previously disciplined.

4. Respondent is an experienced practitioner. He has performed thousands of abortions, including a significant percentage of second trimester procedures. In the last five years, he has performed about 3,000 abortions per year, approximately 20 percent of which have involved second trimester pregnancies. Since 1986, approximately 90 percent of his practice has been devoted to the performance of abortions. Despite this volume, only three patients in the past ten years suffered complications which required hospitalization. Respondent seeks to keep his level of competence by regularly participating in the continuing education activities of the National Abortion Federation.

5. Respondent practices medicine with another physician, operating three clinics in San Bernardino and Riverside counties: one in Victorville, one in Moreno Valley, and the main office in Palm Desert. Respondent is the only practitioner who offers second trimester abortions in a vast area of the state's southeastern desert communities.

6. a. Certain complaints were made to the Board in the late-1980s regarding respondent's care of a number of patients in 1987.

b. Respondent met with representatives of the Board to respond to the allegations. During the meeting, he informed them that he had purchased equipment for his office and that he was performing ultrasound examinations on all patients seeking abortions.

c. The Board did not discipline respondent's certificate as a result of these allegations.

d. Complainant did not establish that as a result of the Board's investigation respondent was ordered to perform ultrasound examinations before each abortion or that respondent entered into any agreement with the Board to do so.

7. For a number of years, the exact figure not stated at the hearing, respondent has performed abortion services under contract for Womancare Clinic ("Womancare").

8. Womancare is a not-for-profit community clinic in San Diego, California. It seeks to provide clients with information about the choices available to them in the area of family planning. If a client elects to undergo an abortion, she is provided an advocate who assists her through the procedure.

9. Respondent worked at the Womancare facility about 3 to 4 times per month during 1992. He is not presently performing such services because of the demands of his own practice.

10. Melisha W., the patient whose care is at issue in this proceeding, was seventeen years old in March 1992. At the time, her height was between 5'5" and 5'6" and her weight was between 140-145 pounds.

11. Melisha W. lived at her mother's home and was covered by her mother's Kaiser medical insurance. Wishing to terminate her unwanted pregnancy, Melisha W. obtained an abortion referral from Kaiser. On February 19, 1992, she sought the abortion at Family Planning Associates Medical Group. The abortion was not performed as the patient was believed to be in her 25th week of gestation.

12. Melisha W. presented herself for an abortion at Womancare on Saturday, March 7, 1992, at approximately 8:46 a.m. Fearing that the clinic would not perform the abortion if she disclosed the truth, Melisha W. lied about her last menstrual period. She reported it to have been on December 31, 1991. The patient otherwise disclosed truthful information to Womancare staff.

13. As part of Womancare's lengthy pre-abortion procedure, Melisha W. completed a number of forms and discussed her desires with staff members. Routine pre-operative laboratory work was performed in advance of meeting respondent.

14. Respondent met the patient in the examining room. Also present in the room was another person utilized by Womancare to act as an advocate for the patient.

15. The relevant standard of care requires a physician to make a reasonably accurate determination of a patient's stage of gestation before undertaking an abortion. The determination need not be absolutely precise, but it must be reasonably close to the actual stage. Accuracy is important because the stage of gestation dictates the degree of cervical dilatation and the necessary equipment and procedure. A more complicated procedure, Dilatation and Extraction, is generally performed in second trimester abortions.

The standard of care requires the performance of a bi-manual pelvic examination as part of the pre-abortion procedure. Palpation of the abdomen is also dictated by the standard of care. The chief reasons for these examinations are the determination of the stage of gestation and the search for potential complications.

16. Respondent did not palpate or otherwise examine Melisha W.'s abdomen, either as part of a bi-manual pelvic examination or independent of such examination.[1]

17. Respondent's failure to conduct an examination of Melisha W.'s abdomen resulted in the significant underestimation of the patient's stage of gestation. He testified at the hearing that he believed the stage of gestation to be between 8 and 12 weeks. However, the patient was actually 25-26 weeks pregnant.

18. Respondent's failure to conduct an examination of Melisha W.'s abdomen is an extreme deviation from the standard of care and therefore constitutes gross negligence.

19. Respondent testified at the hearing that examination of the patient had been difficult. He sought to explain the failure to properly determine the stage of gestation on the likely softening of uterine tissue upon his touch. Two experts testified regarding the potential for error in the determination of the gestation age even if the physician is careful, which potential, although rare, exists because of the composition of the uterus. This testimony, however, is insufficient to establish that such complication in fact occurred in the case of Melisha W.

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[1]The patient's testimony in this regard is credited. On this point she was very certain and her testimony was direct and consistent. Respondent's testimony, on the other hand, was somewhat vague, less direct, and embellished on cross-examination. Moreover, the patient's testimony is corroborated by the existing circumstances: if properly examined, the size of her abdomen should have, at a minimum, raised questions regarding whether said size was consistent with a first trimester pregnancy.

Respondent testified about his extensive efforts to examine the abdomen of a tense and nervous teenager. If this testimony is to be believed, then the activity he described should have been remembered by the patient or by the Womancare advocate present at the procedure. However, the patient credibly testified in direct contradiction.

Also, the person placed in the examination room by Womancare to act as an advocate for the patient was not produced by respondent. Since respondent called other witnesses from said organization, the clinic's lack of cooperation cannot be presumed. In any event, respondent did not show the witness to be unavailable or otherwise satisfactorily explain the failure to call her as a witness. In the existing circumstances, therefore, the inference to be drawn from respondent's failure to call this witness is that her testimony would not have corroborated his.

20. The standard of care further requires a physician to be reasonably certain about the patient's stage of gestation before proceeding with the abortion. If necessary, resort to ultrasound technology must be made to resolve a material uncertainty.

21. Respondent testified at the hearing that his uncertainty regarding the patient's stage of gestation was limited to whether the patient was between 8 to 12 weeks pregnant, which doubt was not material to his ability to perform the procedure. This testimony is in direct contradiction with his statement to Board investigators on January 13, 1994. Then he stated as follows:

> "... Other times you do a pelvic and well, you're not sure. Some patient you are sure -- those you're sure on, you know they don't really need a sonogram. If you're not sure, yeah, this one I should have got a sonogram, in retrospect cause I wasn't sure."

Respondent's attempt to explain away the January 13, 1994, admission was not believable. Accordingly, consistent with the more credible statement to the Board before the start of trial, it is concluded that respondent's uncertainty regarding the stage of gestation of Melisha W. was not limited to the 8 to 12 weeks period. Rather, respondent's uncertainty was of such significance that, by his own admission, sonographic tests should have been performed to resolve said doubts.

22. The equipment to perform the ultrasound examination was available to respondent on March 7, 1992. Although the Womancare protocol did not then require the routine performance of sonograms for teenage patients, the protocol permitted the physician to order one if one was deemed necessary.

23. In the case of patient Melisha W., an ultrasound examination was indicated.

24. Respondent did not order the ultrasound examination and instead proceeded with the procedure.

25. Proceeding with the procedure when by his own admission he was uncertain regarding the patient's stage of gestation is an extreme deviation from the standard of care and therefore constitutes gross negligence.

26. With the patient under local anesthesia, respondent introduced a sterile flexible 9 mm cannula into the uterus. He did not dilate the cervix for the introduction of the instrument. Amniotic fluid was thereafter extracted until respondent realized the amount of fluid was not consistent with a first trimester pregnancy. Respondent stopped the procedure in order to conduct an ultrasound examination. No fetal or placental tissue was aspired.

27. Respondent's conduct set forth in finding of fact numbers 15 through 26 constitutes unprofessional conduct.

28. Sonography results obtained after the procedure had been stopped placed the stage of gestation at 25-26 weeks.

29. After the procedure at Womancare had been prematurely terminated Melisha W. still wished to proceed with the abortion. However, respondent does not perform abortions in the 25-26 week range and he did not believe that anyone in the San Diego area was competent to perform one.

30. Under respondent's direction and supervision, Womancare staff made inquiries regarding the availability of physicians sufficiently skilled to perform the procedure. An appointment was made at the earliest available time, Monday, March 9, 1996, at 8:30 a.m., in Los Angeles, with Dr. James McMahon, a nationally-recognized expert in late term abortions.

31. Melisha W. was released at approximately 2:10 p.m. She was not exhibiting unusual bleeding, pain or signs of infection. The patient was given directions to Dr. McMahon's office. She was instructed regarding potential complications, such as fever, cramping, or bleeding, and was given a twenty-four hour emergency phone number to call in the event of said difficulties. Consistent with Womancare protocol, clinic staff prophylactically administered an antibiotic and .2 mg of Methergine prior to discharge.

32. In the existing circumstances, respondent's failure to admit Melisha W. into a hospital after he stopped the procedure does not constitute gross negligence, negligence, or incompetence.

33. Melisha W.'s mother was nevertheless concerned about her daughter's well-being after her discharge from the Womancare clinic. Accordingly, she took Melisha W. to a Kaiser Foundation hospital. Labor was induced and a girl was born at approximately 8:50 p.m. on March 8, 1992. According to her family, the little girl presently appears to be healthy and normal.

34. Respondent has demonstrated his compassion in his treatment of patients referred to him. Thus, on two occasions in the mid-1980s he accepted referrals involving emergency conditions afflicting indigent patients.

35. Samuel G. Wiltchik, M.D., whose specialty is OB/GYN, testified on behalf of respondent. Dr. Wiltchik attended to two of respondent's patients in need of his services. Respondent provided competent care to these patients prior to the referral and provided all necessary information for Dr. Wiltchik to provide subsequent care.

36. It was not established that respondent's deviations from the standard of care are sufficient to demonstrate incompetence. Rather, this situation involving only one patient in the thousands which respondent has treated in the past five years constitutes a lapse not shown to have been the result of lack of qualification, ability or fitness.

37. a. The complaint regarding respondent's care of Melisha W. was received by the Board in March 1992. The Accusation was filed on April 28, 1995.

b. Even if it is assumed that there was an unreasonable delay in the filing of the Accusation, respondent did not establish that he was prejudiced by the delay. On the contrary, the patient's medical records were available; the experts' review of these records was not hampered by the passage of time; the patient credibly recalled the incident; respondent did not show that he had poor recollection of the procedure; it was not shown that the Womancare advocate present during the attempted abortion was unavailable.

c. In the existing circumstances, therefore, respondent did not establish the affirmative defense of laches.

38. a. The following are the actual costs of investigation and enforcement of this matter:

Category		Costs
Board Investigators		$8,460.10
Medical Consultant		450.00
Medical Experts		975.00
Attorney General Charges		10,259.75
Attorney costs	$10,116.75	
Paralegal costs	143.00	
Total		20,144.85

b. The charges of the Attorney General are deemed to be charges within the meaning of Business and Professions Code section 125.3.

c. In order to recover costs, complainant must prevail on the merits. Inasmuch as complainant only prevailed in part, it is appropriate to award only a portion of the costs. In this case, a 70% fraction is reasonable in light of the allegations established.

d. The reasonable costs of investigation and enforcement are, therefore, $14,101.40 or 70% of $20,144.85.

39. Except as set forth in this Decision, all other allegations in the Accusation lack merit or constitute surplusage.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

DETERMINATION OF ISSUES

1. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2234(b) for gross negligence, by reason of finding of fact numbers 15 through 26.

2. Cause exists to discipline respondent's certificate pursuant to Business and Professions Code section 2234 for unprofessional conduct, by reason of finding of fact numbers 15 through 27 and determination of issues number 1.

3. The reasonable costs of investigation and enforcement are $14,101.40.

4. a. All evidence presented at the hearing in mitigation or rehabilitation has been considered. However, the Order which follows is necessary for the protection of the public in light of the violations established.

b. An oral or written examination, or additional training in the area of abortion practice, is unwarranted as a condition of probation. The violation which was established was not the result of lack of medical qualification, ability or fitness. Rather, it was the result of carelessness with respect to one patient in thousands. The conditions set forth below should enable the Board to adequately monitor respondent's practice to ensure that similar errors do not recur.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. G3711 issued to respondent Joseph Durante, M.D., is revoked. However, revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions. Within 15 days after the effective date of this Decision respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this Decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are

extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

3. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

4. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

5. In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

6. Respondent is hereby ordered to reimburse the Division the amount of $14,101.40 within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Division's cost of its investigation and prosecution shall constitute a violation of the probation order,

unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

7. Respondent shall pay the reasonable costs associated with probation monitoring. Such costs shall be payable to the Division at the end of each fiscal year. Failure to pay such costs shall be considered a violation of probation.

8. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

9. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. Upon successful completion of probation, respondent's certificate shall be fully restored.

DATED: 7/10/96

SAMUEL D. REYES
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

04-28-95

In the Matter of the Accusation Against:	NO. 10-92-16904
JOSEPH DURANTE, M.D. 72205 Painters Path Palm Desert, CA 92260 Physician's and Surgeon's License No. G3711 Respondent.	A C C U S A T I O N

Complainant Dixon Arnett, who as causes for disciplinary action, alleges:

PARTIES

1. Complainant is the Executive Director of the Medical Board of California ("Board") and makes and files this Accusation solely in his official capacity.

License Status

2. On or about September 6, 1956, Physician's and Surgeon's License No. G3711 was issued by the Board to Joseph Durante, M.D. ("respondent"), and at all times relevant herein,

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said Physician's and Surgeon's License was, and currently is, in full force and effect.

JURISDICTION

3. This Accusation is made in reference to the following statutes of the California Business and Professions Code ("Code"):

A. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon."

4. Section 125.3 provides, in pertinent part, that in any order issued in resolution of a disciplinary proceeding before any board within the department, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not

available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

FACTS

5. Patient Melisha W.

A. On or about March 7, 1992, patient Melisha W., a 17-year-old female, went to the Womancare Clinic in San Diego, accompanied by her mother. She went to see respondent for an abortion.

B. Melisha W. told respondent that she was approximately nine (9) weeks pregnant. Respondent believed the fetus was probably 11-12 weeks. Respondent failed to perform an ultrasound examination prior to the attempted abortion.

C. Respondent then attempted to perform a suction evacuation of the uterine contents. He removed approximately 85 grams of tissue that did not appear to be fetal tissue. He realized at this point that the fetus was further along than he had thought, and therefore, he performed an ultrasound. The ultrasound revealed a fetus of 25-26 weeks of gestation.

D. The patient was given an injection of 0.2 mg. IM of Methergine and 14 Demerol tablets 100 mg., and referred to a clinic in Los Angeles, for the procedure to be

completed. The appointment in Los Angeles was for 42 to 72 hours later.

E. Soon after leaving respondent's office, Melisha W. and her mother went to the Emergency Room at Kaiser Permanente Hospital in San Diego.

F. The patient went through labor and delivery and delivered a viable 1 lb. 13 oz. baby girl. The baby had an apgar score of 5 at one minute and a score of 7 at five minutes. She underwent a long hospitalization for extreme prematurity and its predictable complications. The baby also sustained residual scars on her left eyelid and nose from respondent's abortion attempt.

G. On or about January 13, 1994, respondent met with representatives from the Medical Board to discuss this case. During the meeting respondent admitted that he had previously lost his privileges at John F. Kennedy Memorial Hospital and at that time he had been investigated by the Board. As part of that investigation respondent met with the Board and agreed to obtain an ultrasound machine in his office in order to conduct ultrasounds on patients seeking abortions. Respondent stated he had complied with the Board's request and had modified his practice by giving all patients an ultrasound prior to performing an abortion.

H. Respondent stated that he did not perform an ultrasound on patient Melisha W. prior to attempting her abortion, even though ultrasound equipment was available in

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the clinic, because it was not Womancare's protocol at the time to perform ultrasounds.

6. Respondent has subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of unprofessional conduct, as defined by sections 2234(b) of the Code, in that he has committed gross negligence in the practice of his profession, as more particularly alleged hereinafter:

A. Paragraph 5 above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent is guilty of gross negligence in his care and treatment of patient Melisha W. Said gross negligence includes, but is not limited to, the following:

(1) Respondent misdiagnosed the weeks of gestation prior to attempting the pregnancy termination;

(2) Respondent performed an attempted abortion on a patient when he was not certain of the weeks of gestation;

(3) Respondent attempted to perform an abortion without obtaining an ultrasound after he had been told by the Medical Board to only perform abortions after obtaining an ultrasound, and he had agreed to comply with that arrangement; and

(4) Respondent failed to immediately admit the patient to a hospital for immediate treatment when he knew that the fetus was at least 25 weeks of

gestation and he had administered Methergine to the patient.

7. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of unprofessional conduct, as defined by sections 2234(c) of the Code, in that he has committed repeated negligent acts in the practice of his profession, as more particularly alleged hereinafter:

A. Paragraph 5 above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent is guilty of repeated negligent acts in his care and treatment of patient Melisha W. Said acts include, but are not limited to, the following:

(1) Respondent misdiagnosed the weeks of gestation prior to attempting the pregnancy termination;

(2) Respondent performed an attempted abortion on a patient when he was not certain of the weeks of gestation;

(3) Respondent attempted to perform an abortion without obtaining an ultrasound after he had been told by the Medical Board to only perform abortions after obtaining an ultrasound, and he had agreed to comply with that arrangement; and

(4) Respondent failed to immediately admit the patient to a hospital for immediate treatment when

he knew that the fetus was at least 25 weeks of gestation and he had administered Methergine to the patient.

8. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of unprofessional conduct, as defined by sections 2234(d) of the Code, in that he has committed incompetence in the practice of his profession, as more particularly alleged hereinafter:

A. Paragraph 5 above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent is guilty of incompetence in his care and treatment of patient Melisha W. Said incompetence includes, but is not limited to, the following:

(1) Respondent misdiagnosed the weeks of gestation prior to attempting the pregnancy termination; and

(2) Respondent performed an attempted abortion on a patient when he was not certain of the weeks of gestation;

(3) Respondent attempted to perform an abortion without obtaining an ultrasound after he had been told by the Medical Board to only perform the procedure after he had obtained an ultrasound; and

(4) Respondent failed to immediately admit the patient to a hospital for immediate treatment when he knew that the fetus was at least 25 weeks of

gestation and he had administered Methergine to the patient.

9. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234(e) on the grounds of unprofessional conduct, as defined by section 2234 of the Code, in that he has committed acts of dishonesty and/or corruption in the practice of his profession, as more particularly alleged hereinafter:

A. Paragraph 5, above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent is guilty of dishonesty and/or corruption in his treatment of patient Melisha W. In that respondent attempted to perform an abortion without obtaining an ultrasound after he had been told by the Medical Board to only perform abortions after obtaining an ultrasound, and after he had agreed to comply with that arrangement.

PRAYER

WHEREFORE, complainant requests that the Board hold a hearing on the matters alleged herein, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's License Number G3711, heretofore issued to respondent Joseph Durante, M.D.;

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2. Directing respondent Joseph Durante, M.D. to pay to the Board a reasonable sum for its investigative and enforcement costs of this action; and

3. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: April 28, 1995

Dixon Arnett
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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